WDH - Office of Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | WY0027 | A. BUILDING _____ B. WING _____ | 03/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHEPHERD OF THE VALLEY CARE CENTER | 60 MAGNOLIA CASPER, WY 82604 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| SNH | LIC REGS FOR NURSING HOMES<br><br>This State Rules and Regulations is not met as evidenced by:<br>A survey was conducted by the Office of Healthcare Licensing and Surveys on 3/26/11 through 3/29/11. Based upon the findings of the survey team, it was determined that this facility was in compliance with the state requirements. | SNH | | |

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE